MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 12, 2001
10:27 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

Thank you.

DR. KAPLAN: Thank you.

DR. WILENSKY: Thank you, that was a good and appropriately detailed discussion on the inpatient hospital.

Agenda item: Home health services Home health care, Sharon and Sally?

I apologize if there are people who are waiting for public comment, but we're going to go through the end of this since we're already about 45 minutes behind.

MS. BEE: In this session this afternoon we will conclude a discussion that we began last month on whether or not rural home health should be exempt from the home health prospective payment system. Last month we discussed the components of the new PPS, information from the previous cost-based payment system, and additional data needs. Today I'll quickly review our analysis and present two recommendations for your consideration.

The concept behind all of our findings is not whether or not the PPS is doing well, but whether or not it will work differently in rural areas. Our first finding is that the payment unit and eligibility for multiple episodes

together should be able to accommodate practice patterns in rural areas. The 60-day episode should be long enough to allow agencies to manage care within an episode and conform to the majority of length of stay and the schedule for care planning. Potentially longer lengths of stay in rural areas should be accommodated by allowing multiple episodes, so long as the beneficiary remains eligible for the benefit.

Next we find that the base rate plus the 10 percent temporary increase provided in BIPA should capture the costs of care incurred by an efficient provider equally well in urban and rural areas. Two factors could differentiate the cost faced by urban and rural home health providers and might not be adequately accounted for in the payment formula, and those are travel and volume. The cost of traveling to serve a sparse or remote population may increase the cost faced by rural providers.

Rural providers may also be at a cost disadvantage because their low volume may not permit them to spread fixed costs over a large number of episodes. As we noted at the last meeting, there is no data at this time from the PPS to

measure and assess the effects of travel, low volume, or other costs that may cause an efficient rural provider to have higher costs than an urban one.

Next we find that the case-mix adjustment should fix urban and rural beneficiaries equally well. Historically, urban and rural home health users have been clinically similar. Rural users have somewhat more chronic conditions, which is consistent with somewhat longer lengths of stay. And rural users might use therapy differently, but in the past those who have gotten some therapy care usually get the same amount as urban beneficiaries.

Now the use of therapy in home health has been changing recently, and patterns of therapy use are likely to change again under the new incentives of the PPS. As we noted at the last meeting, data that will come from the PPS will allow us to determine whether similar urban and rural beneficiaries receive different care. Based on historic data and the structure of the case mix, we find at this time that it should capture the clinical and functional factors that shape case mix equally well for urban and rural

beneficiaries.

Finally, we find no evidence of access problems in rural areas due to agency closures. The count of Medicare-certified home health agencies doesn't include branches, which GAO found provides a great deal of service in many rural counties. The closures that were reflected in the count of Medicare-certified home health agencies were concentrated in urban areas and not rural areas.

Rural providers were not the dominant source of care in counties adjacent to metro, which is where half of all rural beneficiaries live. Finally, there is still a higher ratio of home health agencies to beneficiaries in rural areas than there are in urban areas.

Given these findings, there is no component of the PPS that should be more or less adequate for rural home health. Continuing the current payment system with the 10 percent increase provided in BIPA to temporarily offset any potential problems in rural areas will allow us to assess the impact of PPS and test any changes that may be appropriate.

I'd like to note that we've used the term services in this recommendation instead of agencies because differences in urban and rural home health payments are determined by the location of the beneficiary rather than by the location of the agency. So at this time we propose to recommend that the Congress should not exempt rural home health services from the prospective payment system.

DR. ROSS: Maybe you'll want to follow the tradition of going all the way through and then coming back.

MS. BEE: This brings us to the second issue, how can data that would allow us to measure the impacts of the PPS be generated? In conducting the analysis for this report we were told not to rely upon cost reports, especially for the data on travel costs that we wanted, because the data is inconsistent from agency to agency. The form of the cost report does not always follow the function of producing the service and guidance to reconcile form and function is unclear.

Cost to provide escorts, beepers or cell phones to employees who see clients in dangerous neighborhoods seemed

to fall prey especially to this inconsistency. Also travel costs which could be counted as direct patient care expense, administrative cost, or a not-allowed cost at all is prey to these inconsistencies.

Problems with the data that we see now are likely to be exacerbated under the prospective payment system as cost reports will not be linked to the agency's reimbursement. What incentive is there for a provider to commit their time and energy to really solid cost reporting if success does not result in better reimbursement and failure does not result in significant penalties?

To address problems with the data, we propose to recommend that the Secretary should improve the quality of data on home health cost reports by substantially increasing the audit rate for cost reports, and clarifying allowable costs and the documentation required. New resources will be required to increase the audit rate. Developing new and meaningful penalties for inaccurate data would also be needed. It may be difficult to generate sufficient incentive without burdening providers and making Medicare's

relation with them an unacceptably punitive one.

In addition to efforts to improve all cost reports, HCFA could create a pool of providers, perhaps the group whose cost reports were used to make the PPS. This group of about 500 providers was thought to have especially good report and with some weights it comprised a nationally representative sample of agencies. New resources would be needed to support continuing comprehensive edits of these reports, and there might be a need for some compensation to participate in the group. However, this pool could provide very good cost data.

In the long run, we will need good data from the implemented PPS to assess whether rural providers will face higher cost per episode than the national mean due to costs beyond their control, and whether similar urban and rural home health users are receiving different services under the PPS. Evaluating these two questions will be essential to understanding the PPS and its impact on rural home health.

MR. DeBUSK: Getting this cost data, we're not even into this prospective payment system -- I mean, we're

just going into it, getting into it, and we go out here and we're going to start really hammering down on trying to get, what does it cost you to provide this service. Then I go back and I look at the OASIS and the HHRGs, seems like we've come right back to the same place every time with burden the whole system with more data, more collection.

A lot of this has got to be counterproductive in our approach on how we do this. You look at the whole OASIS system, you got 80 categories and the whole darn thing could be done with 23. And it takes two-and-a-half hours to fill these things out.

I just guess I object overall to the structure of how we approach this.

MS. BEE: We're not suggesting that there be a new cost report or that there be new data collected. The recommendation is that we audit what we get to see if we can improve the quality of it. And at the same time, if we can clarify what we're asking for, and especially what documentation we're asking for, that might actually ease compliance and improve the quality of data. So we hope that

we have sort of a stick and something of a carrot.

MS. RAPHAEL: I support your first recommendation. I thought you did a very good job and you made a persuasive case in the text.

The second recommendation I find a little more troubling because in your text you talk about the fact that increasing the audit rate can help to improve the accuracy. But then you go on to talk about the fact that right now there aren't really good incentives to produce accurate cost reports and you think that it may be difficult to generate sufficient incentives without burdening providers, and you think this would burden providers. So I'm trying to reconcile this.

Then you come up with another proposition that maybe we ought to use those who were involved in the national demonstration, who really are a good, nationally representative sample, and keep working on their cost reports and trying to understand it.

So that I would wonder why we would want to burden every provider when we don't have the incentives right now -

- and every cost report is reconciled. There is a reconciliation that you go through with your fiscal intermediary. Rather than take this representative group as the group that we've put under the microscope, to really better understand transportation costs and other costs that legitimately need to be paid for, perhaps in a different way.

DR. WAKEFIELD: I came in a couple of minutes late to this so I'm sure I probably missed some comments that you made, so perhaps you'll correct me. But when I read through this chapter and this particular, the first recommendation, my view about this was, I'd frankly rather replace this recommendation and ask the Congress to look at some special payments for -- to assess the need for and develop some special payment methods for low volume, sole community home health agencies.

I think that it's the same notion of trying to determine what's going on with low volume that applies to home health agencies that does to hospitals, as we discussed them in terms of inpatient data earlier. We don't have

enough data on that point.

But I think this recommendation, one, strikes me as a bit draconian because it brings everybody along. I'm not comfortable that, as I said, small, low volume, sole community home health agencies are adequately protected right now in terms of payment policy. So I have a concern about that, about the way this reads, and I frankly would prefer to see it replaced.

DR. WILENSKY: The way which reads?

DR. WAKEFIELD: We're talking about recommendation one.

MR. DeBUSK: I think we've got another problem. I think part of these home health agencies need to go away in these rural areas. I believe propping them up is nothing but a problem. There's too many of them. There's still too many of them. Some of them occasionally will have some hospital relationship there, but then you've got all these that sprung up from this group of doctors refer their patients here, and this here. I mean, there's just so many of those it's unreal.

DR. WAKEFIELD: Can I respond for just a second? My concern is monitoring the impact of the home health agency payment on rural agencies. I take your point about over-supply. I don't think we want to do anything that encourages that. But it's my understanding that HCFA had very little data about rural agencies specifically. They were looking at a very small number when they developed their home health PPS.

In their per-episode demonstration study, about 13 of the 80 agencies that were studied were in rural areas, and only seven of those 80, it is my understanding, were hospital-based. That's according to Mathematica's work. The math of those numbers suggest that as few as one or two of those study agencies might have been rural hospital-based agencies. In 1996, two-thirds of rural home health agencies were hospital based.

So I'm concerned about the data that we're spinning off of in terms of the payment methodology that was developed and whether or not it adequately -- I'm not suggesting all rural hospitals, I'm not defending all rural

hospitals. I'm saying, do we need to be concerned about a subset of those rural -- excuse me, all rural home health agencies. Do we need to be concerned about a subset?

I would suggest we probably do. That the data that the PPS system was built on was pretty small. It was awfully thin.

DR. WILENSKY: I understand the concerns about the data that the PPS was based on, but is that an argument for saying you should just exempt rural home health from PPS?

DR. WAKEFIELD: No, I was saying, I don't think we should put all of rural home health into the same basket. I was suggesting that we take a look at a recommendation that would encourage the consideration of developing a payment that's based on sole community, low volume, home health agencies.

This doesn't provide that consideration. This moves everybody over into one category. I'm saying, could we get consideration for low volume, keeping that theme consistent as we applied it with inpatient hospitals as well. Asking them to look at it. Obviously we don't have

the data on which to base a payment methodology.

DR. ROSS: It's also not exactly parallel because the concept of low volume dealing with an agency versus dealing with a hospital --

DR. WILENSKY: With a high capital structure. The reason that for hospitals low volume becomes such a big issue is hospitals are characterized as high fixed cost, low variable cost institutions. When you have a low volume that really hurts you.

DR. WAKEFIELD: That's a problem.

DR. WILENSKY: My sense is one of the reasons that people have said we shouldn't get too hung up on the number of agencies per se is that agency, expanding service within a given agency, popping up with a new agency when you have very low capital intensive groups like home health, is a very squishy concept. So the number of agencies per se is not a very useful measure because of the fact you don't have the big capital entry barrier that you have with hospitals.

Now I don't have any problem with getting more information on a volume-cost relationship, but I don't think

exempting before we have that information -- I would support the notion of collecting appropriate information so we can see whether or not there may be a differential cost relationship according to volume or sole community. But I would say, go get the data, as opposed to exempting first and then getting the data.

MS. BEE: Is your sense that it wasn't punched enough in the text, or that this recommendation -- as I was trying to craft our support for this recommendation, what I tried to do as well as I could was to say, in the absence of data but from a reasonable theoretical standpoint, we think that the basis is adequate unless the effect of low volume or the effect of travel makes an efficient rural provider's cost higher than urban. And tried to hit a couple of times in the text that those are two costs that we need to look at as PPS is implemented.

DR. WAKEFIELD: What I'd say is I'm looking for, and think that it's important to have some consistency across different agencies, different provider types in rural areas. To the extent that we think that there's something

important about low volume potentially related to high unit costs, not just for inpatient hospitals but also for home health care, then could we also make that a recommendation? To say, could we look at that too? We found it to be pretty important for a subset, just a subset of rural hospitals.

As I said, I want to be very clear, I'm not saying some sort of an adjustment that captures all rural, all home health agencies in all rural circumstances. I'm again trying to think about targeting policy for that provider group that might be out on the front lines, fairly isolated, sole community, that if they weren't there, would put those beneficiaries at risk.

So how do we do that? The first thing I think we have to have is some data, if there are -- there needs to be some pursuit of data that would, at the starting point, show a relationship, if there is one, between high unit cost and low volume with home health agencies. The same principle as we've applied with inpatient hospitals.

DR. REISCHAUER: But I think what Gail was trying to say is there is no strong theoretical reason to expect

that to be the case. There's an issue here that you don't want to make a mistake, and I think that's what you're focusing on. But in the absence of some theoretical reason for why we would expect this to turn out badly, I think the furthest we really should go is to tell the Secretary to monitor carefully the situation in these types of situations because should these agencies face problems, there is no fallback, or the fallback is a long drive away.

DR. WILENSKY: We could modify the recommendation too by including the collection of some of the data that Mary was alluding to. But again, I think there really isn't a reason to expect going in that this should be a problem. But we certainly should monitor it, we should collect the data, see whether or not there appears to be higher unit costs for certain kinds of --

DR. WAKEFIELD: Could then we incorporate some language like that, and consistent with Bob's comment, to ask the Secretary to, as soon as possible, monitor the impact of the home health agency prospective payment on rural agencies?

MS. RAPHAEL: But I think the key variable -- I don't think volume is the issue here. I thin there is an issue about transportation costs, and not having good information on transportation costs. Maybe the second recommendation ought to highlight the need to get better information on what the added costs are of transportation. I think it pertains to inner-city communities as well as to rural communities.

DR. WAKEFIELD: I agree with that too, and I think a recommendation there is, the Secretary should conduct a study to determine if supplemental payments for travel costs are needed in some home health. I would say rural home health agencies. You're putting urban in the mix and I understand that too.

MS. RAPHAEL: I am because I think it's a big issue.

MR. DeBUSK: We got 10 percent now though, right?

MS. RAPHAEL: We have 10 percent till 2003.

DR. WILENSKY: Sharon, you may want to rework recommendation two and come back and let us see the language

tomorrow morning to see whether we've alleviated that concern.

Let's vote on recommendation one and we'll postpone recommendation two until we see the rewording tomorrow morning.

All those in favor?

All those voting no?

All those not voting?

[Next agenda item begins] Craig?

MR. LISK: Good afternoon. In this late hour, we're going to go back again to our mandated report on Medicare payments for nursing and allied health education which is due the end of May. What I want to first do is just briefly review again the congressional mandate. Congress asked the Commission to really focus on two questions.

The questions in the report were, is there a basis for treating different classes of non-physician health care professionals differently in Medicare's payment policies for GME? And what is Medicare's role in supporting clinical